and worse at night. Eight days ago when stooping over felt "as if something had snapped in his head," was dizzy and felt a choking sensation and numbness in R. arm and leg. Was able to walk about after a while and tried to eat but could not swallow. Since then has been unable to eat and even to swallow liquids. Pains in head have continued, but not so marked. For past week has been quite dizzy when making sudden movements. No incontinence of bladder or rectum. Eleven days ago had blurred vision in R. eye, with dark spots before eye and pain. No special difficulty in speaking, but it is somewhat of an effort. Smell and taste unchanged. No locomotor disturbances. Unable to distinguish heat or cold over R. side and extremities. Pupils unequal, the left being smaller. R. normal hippus. Nose and ears negative. Slight droop left corner of mouth, more noticeable when he smiles. Mouth: slight pyorrhea, much dental work. Tongue coated and protrudes to Right of mid-line. Pharynx: Mucous membrane normal, Gag reflex diminished. Neck: Some soreness of muscles on L. Side. Chest expansion good. Heart normal. Lungs normal. Abdomen and back normal. Sensation to pin gone over area supplied by the two upper branches of the trigeminal. Pin sensation over R. foot and lower right leg diminished. Partial ptosis of left eye. Left corneal anaesthesia. Voice has changed since present illness and has become nasal in character.

The only additional data that subsequent examination revealed was that his rhinolalia aperta was caused by a paresis of the left soft palate, and that there was a partial paralysis of the left vocal cord.

Examination of the internal ears showed normal reactions to all tests. Examination with the esophagoscope showed a perfectly patent esophagus, only a slight thickening about the introitus being seen. The instrumentation was done without anesthesia.

When last seen about a month ago he was able to swallow liquids in small quantities, but could not accomplish this if he swallowed too hastily. His sensory findings were as in the first examination. Paresis of soft palate much improved with consequent improvement of speech.

In conclusion it might be said that when confronted by a case of sudden inability to swallow, the syndrome of occlusion of the post. inf. Cerebellar artery, should always be kept in mind.

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REPORT OF A CASE OF THE OPERATION OF BOTTINI FOR PROSTATIC OBSTRUCTION, AFTER TWENTY YEARS, and REPORT OF A CASE OF THE OPERATION OF GARRITY FOR CANCER OF THE PROSTATE, AFTER SIX MONTHS.*

By GRANVILLE MacGOWAN, M. D., Los Angeles.

CASE I.

In the autumn of 1898, J. R., a physician living in Mifflinsburg, Pa., and temporarily visiting in California, after suffering for about a year at intervals with symptoms of prostatism, which for several months had required the leading of a catheter life, appeared for consultation, stating that he had read an article in which I had reported the successful use of the Bottini instrument in the relief of prostatic obstruction, and that he desired that I should carry out this treatment in his case. He was suffering, at the time, from acute cystitis, and the passage of a catheter was very difficult and very painful. An inlying catheter could not be borne.

The case did not seem suitable for this operation and I advised a prostatectomy, but he insisted on the Bottini or nothing.

Three incisions were made with the cautery on the floor of the bladder outlet. He had a very stormy time for about two weeks, with high temperature, great pain, some delirium, but in the end, the operation afforded him all the result which he desired.

The groove left permanently was sufficient to enable him to empty his bladder. The frequency decreased as the years went by. He became intellectually and physically active again. About 1906 he married. He had retained his sexual powers, up to my last interview with him, which was last December. He has returned to California every winter, and I have been afforded the opportunity to cystoscope him each year, and catheterize him; there is no residual urine, but the urine has never been clear.

The frequency is not great, four or five times during the day and twice at night. The bladder is still trabeculated. The lateral lobes of the prostate can be seen projecting into the bladder, the left being the larger, but they do not impinge upon the groove made by the Bottini.

At the time of the operation, he was fifty-eight years old; he is now seventy-nine.

In the last five years of the nineteenth century, I was using the Bottini rather frequently, having operated then altogether about fifty cases. We had not yet worked out the technique of safe prostatectomy which has been established since, as the result of the effort of many of we older men, over a period of a quarter of a century, so that the Bottini operation with all its dangers appealed to me then, as it did to other men, like Hugh Young and Cabot, as well worthy of regard.

A few years later, owing to an unfortunate accident, I abandoned its use altogether. This case stands as an exemplar of the fact that what the Italian surgeon who originated the cautery operation claimed for it, is true, which is that the operation itself could be used for the establishment of bladder drainage, that would successfully allow of the emptying of the bladder in cases of hypertrophied prostates without removal of the encroaching growths.

CASE II.

In my service at the Santa Fe Railroad Hospital in Los Angeles. F. C. B., engineer, aged 62, referred to me by reason of his inability to urinate. Symptoms of prostatism developed quite suddenly early in October, 1917; before that time, he had never had any difficulty in urinating and no history of pain, but in the interval the symptoms of prostatism had increased until when I first saw him, retention was complete.

Rectal examination showed a very large prostate, indurated, immovable on the right side and very slightly movable on the left, apparently adherent to

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the muscles of the rectum and extending out along and involving the right seminal vesicle.

Cystoscopic examination showed a bladder not trabeculated and not inflamed; the outlet was irregular in all zones, but presented no distinct bulges into the bladder.

Diagnosis—Cancer of the prostate.

An ordinary case would have been given a catheter and sent home, but this man was not teachable and there was no one in his home hamlet to catheterize him. He preferred to be operated.

The case seemed suitable for the operation, which had been devised by Dr. John Garrity for the total ablation of the prostate, in cancer, which he was kind enough to explain to me at a visit with him last June. This operation is a perineal one and differs in several features from operations devised by Dr. Hugh Young and the one devised by me, and is an improvement on both of them.

On the 3d of August I submitted him to this operation. The prostate, its capsule and both seminal vesicles were removed. The bladder neck was involved for almost its entire circumference. The cancer was removed from this with cutting rongeurs. It took a long time. The work had to be patiently done; when we ceased everything that was indurated or that felt or looked cancerous had been removed excepting a small nodule far up on the right side underneath the lateral bladder wall, which could only be felt; it could not be brought down. Two tubes were inserted, one through the urethra and the other through the perineum, coming out on the left side. On the 9th of August, the stitches were removed and both tubes taken away from the bladder; on the 16th of August, he commenced to pass urine by the urethra; on the 19th of September, he was passing all of his urine through the urethra and has continued doing so ever since.

He was examined on the 10th of September with the cystoscope, which demonstrated a clear bladder wall, and a very fair bladder neck, though there was some edema on the right side of the bladder, about the neighborhood where I did not reach all of the growth. On the 3d of January of this year, he was in excellent condition; his bladder showed a little more edema on the right side; he was holding his urine from three to four hours with a bladder capacity of 250 cm., and passing it in an excellent stream.

He was examined again on the 10th of March; at that time I could notice, with the finger in the rectum, a recurrent growth at the site of the edema in the bladder, but he stated that his bladder condition was entirely comfortable. He complained of pain over the left hypochronrium and of some cough. I made a diagnosis of cancer of the lung and possible involvement of the liver; he was referred to the medical department and Dr. Sugarman made the following report to me within the last forty-eight hours:

Chest findings: Apex at the fourth interspace, superficial dullness (cardiac) reveals heart dislocated up and left; no valvular lesions. Marked dullness over lower sternum to left lower chest. Respiratory excursion left diaphragm limited; massive dullness basal left with marked reduction of vesicular breath sounds. Thoracentesis shows sero sanguinous effusion. X-ray, chest dense shadow in inferior mediastinum sharply defined nodules (size of walnut), scattered through left lung.

Diagnosis: Mediastinal tumor of malignant origin.

I must say, with regard to such operations, that after having performed a number of successful resections of the prostate, meaning by that, that the individuals have retained their urine, have urinated freely and emptied the bladder for at least a time, as I am doubtful as to whether they are justified in the premises. Nearly always metastasis has already taken place before the process in the prostate has so far advanced that it can be almost absolutely determined by the tactile sense alone.

While the disease may be locally cured, the surgery performed, exhausting, long, tedious as it is, really does not, in the end, pay, because it does not lengthen the individual's life nor does it greatly increase his comfort, and, as a rule, I am inclined to advise against such operations.

Dr. Molony of San Francisco and Dr. Lyons of Wichita, with several Texas and California physicians whose names I do not rembember, were present at the operation.

THE INTENSIVE TREATMENT OF MENINGOCOCCIC MENINGITIS.*

By DONALD J. FRICK, M. D., Los Angeles.

It is a peculiar fact that in medicine as in life generally we only learn by hard knocks. We do not seem to be able to apply quickly the lessons learned in the treatment of one disease to other diseases which are produced in a similar way, but have dissimilar manifestations. We have been impressed for a number of years by the advisability and necessity of intensive treatment in diphtheria, we have seen numbers of cases of tetanus recover following the employment of the "Rational" method of Ashurst and John, pneumonia Type I has been treated with large amounts of the specific serum with wonderful results, but not until we were placed face to face with the virulent epidemic of meningitis of last winter did we use our knowledge gained in these other diseases and evolve a satisfactory plan of intensive treatment. Report of the Surgeon-General, U. S. Army 1918, shows there were 600 cases with mortality of 26.83% for the last four months of 1917.

The preliminary report of Major Herrick in the Journal of the American Medical Association and his later extended report in the Archives of Internal Medicine advocating the combined intravenous and intraspinal treatment should have awakened every one of us to the necessity of intensive treatment, but from the reports of cases of chronic meningitis, cases needing intraventricular drainage with introduction of serum, cases still being treated with intraspinal injections alone or

*Discussed by Drs. Brem, P. R. Brown, Fulton, Roblee, Oliver, Frick.